# DEPARTMENT OF HUMAN SERVICES

# FATALITY REVIEW REPORT

## FY 2005

**Compiled by**
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# DEPARTMENT OF HUMAN SERVICES
# FATALITY REVIEW ANNUAL REPORT

**JULY 1, 2004 – JUNE 30, 2005**

## EXECUTIVE SUMMARY

Department of Human Services (DHS) Fatality Review Policy requires a review of all deaths for which there is an open case at the time of death or where clients have received services through DHS within twelve months preceding their deaths. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs. For example, there appeared to be a need for both Division of Child and Family Services (DCFS) caseworkers and Division of Services for People with Disabilities (DSPD) support coordinators to be trained on safe sleep practices for infants. DCFS developed training on this subject, current DCFS and DSPD staff received the training, and DCFS has incorporated it into the New Employee Training Program, which will be taught during an employee's first nine weeks of work.

During FY 2005, one hundred six deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were nine suicide deaths (8%) and four homicides (4%). The reviews indicate that abuse and/or neglect were contributing factors in five (5%) of the one hundred six deaths. The Division of Child and Family Services (DCFS) reported that three children died as the direct result of abuse or neglect by their parents/caretakers. The deaths of two individuals receiving services through the Division of Services to People with Disabilities (DSPD) could be linked to the failure of contract providers to provide appropriate client supervision and/or to obtain prompt medical care.

DCFS, DSPD, and the Division of Juvenile Justice Services (DJJS) Fatality Review Committees reviewed the deaths of ninety clients (93%). Utah State Developmental Center (USDC) conducted two on-site reviews with three reviews pending, and Utah State Hospital (USH) conducted two on-site reviews. The DHS Fatality Review Coordinator conducted a written review on one Division of Aging and Adult Services client. The Office of the Public Guardian (OPG) reported seven deaths and provided the Fatality Review Coordinator with comprehensive written reports covering services to these clients.

Deaths were almost equally divided between males and females with reports of fifty-two males (49%) and fifty-four females (51%). Fifty-one clients (48%) were between the ages of birth to eighteen years; twenty-four (23%) were between the ages of nineteen to fifty years; and thirty-one clients (29%) were between the ages of fifty-one to eighty-eight years.

# FINDINGS

The purpose for reviewing a Department of Human Services client death is to assess the Department's culpability in that death, to develop means for preventing future client deaths, and to improve Department services. The review itself evaluates the system's response to protecting vulnerable clients by assessing whether best practices were followed in the case.

During FY 2005, the DHS Fatality Review Committees reviewed the cases of 106 individuals who had received services through the Department within twelve months of their deaths. Of that number the Committees determined that in 101 cases (95%), the provided services did not contribute to the clients' deaths. The Committee felt that in five cases (5%) the abuse and/or neglect of a parent, caretaker, or contract provider contributed to the death of the individual.

Of the forty reported child fatalities, three deaths (8%) were attributed to abuse or neglect by a parent or caretaker. A seventeen-month-old male died after being physically abused and suffocated by his parents. At the time of the child's death DCFS had an open CPS investigation on this family, and the AAG was preparing to petition the court for court-ordered Protective Supervision Services (PSS). Both parents have pleaded guilty to Child-abuse Homicide.

Another seventeen-month-old female died of inflicted head trauma/Battered Child Syndrome from injuries inflicted by her father. Less than a month before the child's death, her family had been the subject of an unsupported (later changed to supported) CPS investigation on an allegation of Physical Abuse – Severe after the child suffered a broken arm. The decedent's father is charged with Murder, a first-degree felony.

The third child, four years old, died of blunt trauma to the head inflicted by his mother's boyfriend. Five months before the child's death, his family had been the subject of an unsupported CPS investigation alleging Child Endangerment. Neither the decedent nor the boyfriend was named in the investigation. The boyfriend has been charged with 2$^{nd}$ Degree Felony Child Abuse Homicide.

Of the forty-four individuals who died while receiving services through DSPD and its contract providers, the deaths of two individuals (4-1/2%) raised concerns about whether the contract provider obtained timely and adequate medical care for them. One individual's residential provider seemingly ignored the concerns of the day provider regarding changes in the man's physical appearance and behavior. When medical treatment was sought for the men, he was diagnosed with a urinary tract infection that was septic. The man died of sepsis due to a urinary tract infection. After undergoing surgery for a deep decubitus ulcer that had developed on the back of his thigh, another individual developed pneumonia and a particularly aggressive form of staph infection and died of respiratory failure.

The DHS Fatality Review Committee members identified numerous strengths in service-delivery systems that included noticeable improvement in child welfare's involvement of families in service planning; more aggressive seeking of appropriate kinship placements; and on the part of DSPD Support Coordinators, increased attention to the Health and Safety issues of their clients. Committee members also singled out several areas in which changes or modifications could enhance systemic response to the needs of Department clients that included better assessments of parents' and children's underlying needs, better matching of the level of services to the level of risk of harm, and better monitoring of contract providers. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff.

# BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to train staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements.

The fatality review committees consist of a Board member of the Division under review, the Attorney General or designee, a member of management staff from the designated Division and from a region other than that where the fatality occurred, a member of DHS Risk Management, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee, a member of the Child Welfare Legislative Oversight Committee, and any individual whose expertise or knowledge could significantly contribute to the review process. The Child Fatality Review Committee was strengthened this year by the addition of a pediatrician. His expertise on medical issues has provided valuable insight on many of the cases reviewed.

The Child Fatality Review Coordinator receives notification of client deaths through several channels, e.g., Deceased Client Reports, Certificates of Death, the State Medical Examiner, obituaries, emails, etc. In the case of child fatalities, the Coordinator receives Certificates of Death for every child who dies in the State of Utah. After searching the child welfare database, SAFE, to determine if the family has had services within twelve months of the fatality, the Coordinator requests and reviews the case file, summarizes the family's history of involvement, and makes an analysis pertaining to case practice and agency culpability.

Prior to the monthly DSPD and Child Fatality Review committee meetings, members are furnished with copies of fatality review reports, which they study and note areas for discussion. When deemed appropriate, the Committees invite Division staff and/or contract providers to committee meetings to provide additional information. The reports are then sent to the DHS Executive Director, the Director of the Division, and the Director of the region in which the fatality occurred. The Region has fifteen days in which to formulate a reply and, if necessary, an action plan for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Services, that committee meets on an as-needed basis.

The DHS Fatality Review Coordinator is a member of the State Child Fatality Review Committee, which is coordinated by the Department of Health's Violence and Injury Prevention Program (DOH/VIPP). The Child Fatality Review is a collaborative process that brings people together from multiple disciplines to share and discuss comprehensive information on the circumstances leading to the death of a child, to identify preventable deaths, and to identify interventions to prevent future deaths.

The Early Response Team, reviews deaths in Utah that occur to all children aged 0 – 19 years for all causes of death and aged 0 – 21 years for suicide deaths. Committee members provide social and medical information concerning the decedent's family, which is entered in the Department of Health's child fatality database. This information is used in compiling statistics pertaining to birth defects, congenital anomalies, suicides, abuse, neglect, and accidental deaths. Utah is one of thirteen states participating in a pilot program using a standardized form for gathering information pertaining to child fatalities.

The State Child Fatality Review Committee, also coordinated by the Department of Health Violence and Injury Prevention Team, meets bi-monthly (Rapid Response Meeting) with the

State Medical Examiners to discuss child fatalities for which an autopsy has been performed due to the child's death having happened under violent, suspicious, unattended, or unknown circumstances, or for those children who have committed suicide. This group is made up of representatives from Primary Children's Medical Center's Safe and Healthy Families Team, the Birth Defects Network, the Office of the Medical Examiner, Emergency Medical Technician Services, law enforcement, the Office of the Attorney General, the Office of the Guardian ad Litem, the Children's Justice Division, the State Office of Education, the Department of Human Services, Valley Mental Health, the PCMC Child Advocacy Team, the Shaken Baby Foundation, and the Division of Child and Family Services.

Some of the accomplishments of the State Child Fatality Review Committee include the creation of a Suicide Task Force, partnering to complete a six-phase Youth Suicide Study, working toward more comprehensive child restraint and seal belt legislation, and developing news releases, public service announcements, and media events to address the most common injuries among Utah's children. Information gathered is used in the development of public awareness programs for child safety. A current media campaign stemming from the State Child Fatality Review Committee focuses on making the public aware of the high number of child roll-over/back-over deaths.

# DIVISION OF CHILD AND FAMILY SERVICES

**SYSTEMIC STRENGTHS**

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continues to improve over casework conducted prior to the advent of the Practice Model. In most cases reviewed workers saw the child within priority timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, were aggressive in seeking appropriate kinship or foster placements. With the advent of the Practice Model, caseworkers are conducting frequent Child and Family Team Meetings and are working more closely with clients in an attempt to identify client needs and to plan appropriate services. In most cases reviewed, workers appeared to be diligent in removing children from high-risk situations.

The Child Fatality Review Committee recognized the excellent work of Child Protective Services investigator Jeanine Benson for facilitating the removal of a medically fragile infant when it became apparent that her mother could not provide appropriate care for her. Ms. Benson is credited with saving the baby's life by placing her in an environment where she could receive the intensive medical care she required.

The Committee also recognized CPS investigator Leon Butler for his cultural sensitivity while investigating the source of alleged physical abuse in an Asian family. Mr. Butler also took the time to explain the family's customs and methods of treating illness to the alleged victim's school teacher.

Dorothy Pendleton was commended for her outstanding casework and support to a medically fragile child and her foster parents. Ms. Pendleton coordinated an extensive team of service providers who worked to provide the child with the best possible health care and quality of life.

Commendations went to In-home worker, Shari Gillins, secondary worker, Tyler Goddard, and community partners who provided on-going services to stabilize a family and to insure that the medically-fragile baby received appropriate medical care. The team provided a Spanish translator at all meetings and visit, and facilitated the father's obtaining a Green Card and work. When the case was transferred to the Cedar City office, the Beaver office DCFS service team carefully coordinated the transfer of services and requested to remain on the case. A Spanish-speaking secondary worker from the Cedar City office was assigned to the case as well.

The Committee also commended Northern Region for taking immediate steps to conduct an internal review on a case in which the child died of physical abuse. The region is commended for taking an in-depth examination of case practice and for its formulation of an action plan addressing practice concerns.

Acknowledgement was made of the foster and adoptive families of medically fragile children. These families are devoted to the children, insure that they receive appropriate medical care, and commit to providing a home and family for these time- and labor-intensive children.

**SYSTEMIC WEAKNESSES**

In the course of case reviews the Child Fatality Review Committee identified perceived systemic weaknesses and noted deviations from "best practice" casework. In the forty DCFS cases

reviewed, the following issues raised the greatest concern among committee members. It is recommended that during FY 2006, DCFS concentrate on improving case practice in these areas.

***Accessing Case Histories/ Assessing Underlying Needs/ Level of Risk - Level of Services***
Because reviewing a family's history of DCFS involvement is integral to the needs-assessment process, to determining the level of risk, and to determining the appropriate level of services, these areas will be combined for the purpose of this review.

The Committee noted that many caseworkers are documenting in their activity logs that they have reviewed a family's history of involvement with DCFS. However, it appears that some workers are merely looking at the service screen in SAFE for a quick overview of agency involvement and are not actually reading past referrals for additional information, e.g., the reasons for a family's involvement with DCFS, the types of services that have been offered, or the family's level of cooperation and compliance. Case histories can be a factor in determining whether or not court-ordered services are needed and can be an indicator of heightened risk of harm to the child(ren). In eight of the forty DCFS cases reviewed (20%), the Committee expressed concerns that the families' patterns of abuse or neglect warranted more intensive services than were offered.

The Committee reminded the Division that families are best served when the worker is familiar with the DCFS history and that it is not inconsistent to look at a case with a holistic approach. Some workers are of the opinion that they do not want to review the case history before conducting an investigation, as they want to be objective in their approach. Some workers feel the Division owes a family the opportunity to show that they have made changes. Other workers feel they are being judgmental if they read the history and use that information in their investigation. It is only through making an accurate assessment of the family's child welfare history that a worker can determine if services are needed and what level of services is appropriate for the family.

The Committee recognizes that there are problems associated with a worker's obtaining an entire case file, especially in cases where a family has an extensive history of DCFS involvement. Some files are archived and others can be incomplete or lost. Services are sometimes listed under various surnames for the mother, and portions of the file might be located in different offices if the family has relocated throughout the years. However, with the advent of activity recording in SAFE (approximately 1997) a record of a family's involvement with DCFS since that time is immediately available to a worker.

A worker's failure to carefully review a family's history can hinder CPS investigations and can contribute to unsupported allegations or to the worker's offering a lower level of services when a pattern of abuse/neglect might indicate that a higher level of risk is present.

In fifteen of the forty DCFS cases reviewed (37.5%) it appeared that the workers had not adequately reviewed the family's DCFS history, conducted appropriate assessments to identify the underlying needs of their clients, or matched the level of services to the level of risk. The following scenarios are examples of these problems:

> In one case DCFS appeared to repeatedly treat a family with an extensive history of substance abuse as first-time offenders. The Division gave the parents numerous opportunities to correct the problems that had brought their children into DCFS custody. The parents' history of non-compliance warranted more intensive services after the birth of a new baby.
>
> A mother's history of substance abuse, multiple moves, and failure to send the children to school created a red flag as to the need for court-ordered services. However, the Division

conducted and unsupported allegations in eight CPS investigations, as well as conducting two investigations where the family could not be located, before any action was taken. Although the CPS investigators documented that things seemed in order in the family, there was always the underlying issue of the mother's alcohol abuse. Little was done to follow through with determining if the allegations of substance abuse was true, and no services were provided that addressed that problem

Intake provided the CPS worker with the information that a mother had had "two other children taken from her by DCFS", but it was two and a half weeks into the CPS investigation before the worker reviewed the family's DCFS history and learned that the mother had voluntarily relinquished her parental rights to two children and that they had been adopted. It was over three weeks into the investigation before the case was staffed and the decision was made to file a PSS petition. However, eleven days after the case staffing and before the petition could be filed, the four-month-old baby died as the result of physical abuse at the hands of his parents. The facts known before the baby died and the history of this case seem to indicate that there was a need for more aggressive measures on the part of the Division, and a higher level of intervention at an earlier point in the investigation.

A family had a DCFS history spanning nine years replete with CPS referrals alleging Physical Neglect, Domestic Violence Related Child Abuse, and Child Endangerment. There were four unsubstantiated investigations into allegations of abuse/neglect before there was a substantiation. There were numerous allegations that the children's parents and/or paramours were using drugs, and the father had an extensive history of involvement with law enforcement and the court system. However, there were fifteen services, e.g., CPS, DVI, DVS, before voluntary in-home services were opened. When the family did not cooperate with voluntary services, the case was closed. The family was involved in seven more services before the children were removed from the home. Although this family had a clear pattern of abuse and/or neglect, services were not provided until several years into the Division's involvement with them. Even then, the services did not match the level of risk.

One father's DCFS history spans sixteen years and involves a wife and at least three additional paramours, termination of parental rights on three children, and CPS investigations involving additional children. Although the underlying issue of substance abuse was ever present with the father and each of his partners, little, if any, progress was made in treating it.

In the case of a fourteen-year-old with mental health problems, the In-home worker petitioned the court for case closure at a time when the youth was facing major transitions in his life. The relatively-new caseworker had not developed a close relationship with the boy and saw him infrequently. Due to medical insurance issues, the youth was being forced to change from a trusted therapist to a new one. He was also preparing to begin a new school year. DCFS supports were terminated at a critical time in the boy's life. The boy died three months after case closure of methadone poisoning from taking his mother's pills

A family with eight children, ages eight years and under, has been the subject of numerous CPS investigations alleging Physical and Environmental Neglect. It appears that the underlying causes for the family's dysfunction, e.g., the mother's mental health issues, both parents' lack of parenting and homemaking skills, depression, and eight very young children, have not been adequately addressed. Voluntary in-home services on two occasions have failed due to the parents' lack of cooperation. Additional CPS referrals on this family are inevitable.

***Collateral Contacts/Information Corroboration***

In seven of the forty reviewed cases (17.5%), caseworkers failed to interview collateral contacts to gain additional investigative information or to corroborate information provided by clients.

> In interviews with the parents of a four-month-old infant the CPS worker relied solely on the self-report of the parents stating that they had not been physically abusing their four-month-old baby. The worker failed to talk with the referent, who was the mother's therapist, or to obtain the name of the witness to the mother's alleged slapping of the child. Based on the mother's prior voluntary relinquishment of her parental rights to two older siblings, it was crucial for the worker to obtain verification of the parents' statements, as there may have been grounds to remove the baby. While the CPS case was still open, the baby died of asphyxiation and physical injuries after his parents wrapped a blanket around his head to keep the pacifier in the baby's mouth to prevent him from crying.
>
> In another case the mother in a family with a lengthy history of DCFS involvement gave many excuses for her inability to work the service plan, but the In-home worker did not corroborate those excuses with third parties. The Family Preservation Services worker advised that the family did not need PFP services, as they had "a support network". However, he based his recommendation on the self-report of the family and did not verify the family's support network.
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> In a CPS investigation on this same family, the worker based most of his investigation of the allegation that the two-year-old son was "always unsupervised around the apartment complex" on the mother's self-report and made no attempt to talk with the referent or other residents of the complex who might have had knowledge of the family's supervision issues. The case was closed with the allegation unsupported. Four weeks later the toddler died when his mother drove over him in the parking lot.
>
> The worker accepted the self-report of the parents about their lack of drug use, and she did not contact collateral sources to verify that the children were being appropriately supervised if the parents were away. The worker also failed to verify that the father was in DV counseling or that the children were receiving mental health treatment.
>
> A mother self-reported that she had accessed mental health services and that she had obtained a Protective Order. However, the workers did not verify this information. In another case the parents had histories of alcohol and drug abuse, but the worker failed to verify information given by the father that he had completed a substance abuse program. A CPS investigator unsubstantiated the allegation of Non-supervision despite his own documentation that the children were not being appropriately supervised when they played outside. The worker chose to give more weight to the mother's self-report that she always supervised her daughter than to the information provided by the referent stating that the children frequently played unsupervised in the street.

## DIVISION RESPONSES TO RECOMMENDATIONS

The Child Fatality Review Committee commends DCFS for the thoughtful and thorough responses the regions have provided to the Committee's concerns and recommendations. Regions have the opportunity to disagree with Committee recommendations and to explain their rationale for practice decisions. If regions agree with the recommendations, they formulate an action plan for implementation of those recommendations.

In response to the Committee's recommendation that the Division train caseworkers on issues related to recognizing drug abuse and to dealing with parental denial of substance abuse, Salt Lake Valley Region responded:

> "This issue has been referred to the regional training unit for development of specific training in the area of recognizing substance abuse and developing skills for dealing with parental denial of substance abuse. Annually, Salt Lake Valley Region holds one-day training sessions called a "summit" with caseworkers, according to assignment. A specific summit for CPS caseworkers is now being developed with a component specific to recognizing substance abuse and skills in dealing with client denial."

Another Committee recommendation was related to training DCFS caseworkers and DSPD Support Coordinators on safe sleep practices for infants. Salt Lake Valley Region responded with the following action plan:

> The regional trainers have compiled the current literature available on safe sleep practices for infants and prepared the information for presentation. The first scheduled presentation is for regional administration on February 3, 2005. Each CSM or leader of a team will receive a demonstration of the training and a copy of the power point presentation on CD to take to their teams to train them. Each team leader will receive samples of all the materials, literature, and order forms to provide for their own neighborhoods and foster parents. Every team in the Salt Lake Valley Region will complete training by March 31, 2005. DSPD Support Coordinators will also receive this training at that time. In addition, this training will become an on-going part of the New Employee Training Program and will be taught during the first nine weeks of DCFS employment. The name of each person who completes this training will be kept in the database by the Salt Lake Valley Training Academy."

Northern Region administration conducted an internal review on a case in which a sixteen-month-old child died as the result of physical abuse by her father. The reviewers identified several practice concerns and formulated the following action plan:

> "CPS staff in the region has been notified that administration expects that in any case where there is a non-verbal child and where there are broken bones, burns, or other serious indicators about the child's physical condition, that the worker will make contact with one of the two Children's Justice Center nurse practitioners in the region. The NP will review the medical records, may make a contact to emergency departments or other medical providers to sort through the information and, in general, will consult with the worker prior to the closure of the case."

The DCFS Constituent Services Specialist tracks Child Fatality Review recommendations and ensures that regions are responding to the Committee. The regions are to be commended for their thorough and thoughtful responses to Committee recommendations.

# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

## COMMUNITY PLACEMENTS

**SYSTEMIC STRENGTHS**

DSPD Support Coordinators act as advocates for individuals receiving services through the Division and through its contract providers. The DSPD Fatality Review Committee commended staff of several contract providers and a DSPD Support Coordinator for their excellence in caring for individuals.

Danville Services staff was commended in two cases for the extra care they gave to individuals. One individual, dying from San Filippo Syndrome, became increasingly tired and sleepy and lost interest in eating. Staff pureed her food and spent two to three hours feeding her to insure that she ate her entire meal. Another individual suffered from PICA, and staff followed support strategies to protect the woman from ingesting foreign objects or substances in the environment that could have been injurious to her.

During a client's numerous hospitalizations, TURN staff remained by his bedside to insure that he received the best possible care. In the group home staff provided a comfortable environment for the man. They obtained Hospice orders from two physicians, which allowed the man to die at home in the presence of his family and friends. TURN staff became another individual's surrogate family, and provided care for the woman that was "far in excess of that for which they were contracted".

UCP Group Home II staff carefully monitored the health of a medically fragile individual. Staff requested explicit instructions from the woman's doctor on her care and requested additional nursing hours as the woman's condition deteriorated. The woman received Hospice Care and was allowed to remain in the group home until her death.

In their care of an individual, TKJ staff was extremely attentive and supportive of his needs. They insured that he had a healthy diet, that he participated in an exercise program, and that he had appropriate medical and dental care. Staff reacted quickly to a medical need by taking the individual to the emergency room for treatment when his primary care physician was unable to see him. Staff also assisted the man with financial planning, with transportation to community events, and in learning to read.

Douglas Hicks, a job coach through LINK, worked with an individual for ten years, aggressively assisting him in applying for, interviewing, and obtaining employment. Due to the individual's inability to maintain employment for more that a few months at a time, Mr. Hicks employed the man in his private business and paid him from his personal funds while still actively helping the man pursue his dream to work in a bookstore.

Support Coordinator Maureen Richardson was commended for providing "strong advocacy" for an individual by obtaining increased supports that allowed the woman to live in an apartment while being assisted in following a nutritious diet and in monitoring her weight. Ms. Richardson also provided support for the woman's mother and family while the individual was hospitalized prior to her death.

**SYSTEMIC WEAKNESSES**

***Monitoring of Contract Providers***

In two cases (5%) the failure of the contract provider to obtain timely and appropriate medical treatment appeared to be linked to the death of two individuals who were receiving services through the same provider.

> An individual was hospitalized due to a severe "breakdown wound", infection, and fever. The wound was so deep that it required surgery. After surgery the individual was transferred to a care center, as his wound required intensive long-term treatment and was highly susceptible to infection. While in the care center, the individual developed pneumonia, was re-hospitalized, and was placed on a ventilator to assist him with breathing. Within a few days the client died of pneumonia. There is concern that a pressure sore so deep and severe could develop without detection, especially when the individual was receiving Home Health Care services. Early detection of the pressure sore could have led to less-invasive methods of treatment and less compromise of the individual's immune system.
>
> Residential staff for another individual seemingly ignored the verbal and written concerns of day staff about the changes in the man's appearance and behavior, indicators that he was not feeling well. Residential staff attributed the individual's lethargy to his being "bored" at work. After finally taking the individual to the doctor, residential staff failed to relay all of day staff's concerns about the man's symptoms, a task he could not do for himself. The residential provider also failed to notify day staff or the DSPD Support Coordinator that the individual had been to the doctor. It was also nearly a month after the individual's death that the residential provider supplied DSPD with copies of medical treatment records from the year preceding the death. The failure of the residential provider to supply current medical information and/or incident reports to day staff and the Support Coordinator hinders their ability to make accurate assessments of their clients' well being.
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> Another contract provider was reviewed due to reports that there were times when staff ratios were too low to meet the needs of the consumers, that staff was not being trained to the individual physical, medical, and behavioral needs of each client, that staff was not consistently performing daily recording on some behavior plan issues due to lack of training, and that Person Centered Plans were missing from the on-site file.

## DIVISION RESPONSES TO RECOMMENDATIONS

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action that they initiate to comply with recommendations, and for their formal written responses to the Fatality Review Committee.

In regard to the first two cases cite above, DSPD developed an amendment to the provider's contract clarifying medical and information-reporting requirements. They also instructed Support Coordinators to use the Person Centered Planning document as a vehicle for describing how information would be shared with other providers. The Division reminded the residential provider of their contractual responsibility to assure the health and safety of all the people to whom they provide supports, which required that they report health and safety issues to Support Coordinators when they occur, complete incident reporting within contractual time frames, and share information with other providers as outlined in Person Centered Plans. The provider was

made aware that failure to comply with the provisions of its contract with DSPD could lead to the imposition of sanctions.

In response to concerns about the provider in the third example, DSPD Supervisors, Quality Management Specialists, the Regional Director, and Support Coordinators conducted surprise visits to all facilities operated by that provider. They found that some facilities were understaffed, which sparked a major review of the provider. The review uncovered the fact that hours billed by the provider were in question and that they would result in the provider's making a payback to the Division.

## UTAH STATE DEVELOPMENTAL CENTER

### SYSTEMIC STRENGTHS

In the cases reviewed by the fatality review committee, it appeared that individuals at the Utah State Developmental Center (USDC) are served by dedicated, caring, and, generally, well-trained staff. They receive excellent on-going medical, dental, and mental health treatment, medication management, and close supervision. Developmental Center staff is trained to respond rapidly to emergency situations, and staff members have established a good working relationship with community medical providers.

USDC administrative team members consistently conduct thorough and productive fatality reviews. The decedent's service team attends the fatality review and reports on circumstances surrounding the death, answers questions, and clarifies information for committee members. The service team is then excused, and committee members note any irregularities in case practice, policy compliance, or systemic performance. The committee then makes recommendations for systemic improvement and for improved individual care. If warranted, Developmental Center staff members receive in-service training on policy, procedure, and service delivery. If necessary, administrative team members consider systemic changes.

### SYSTEMIC WEAKNESSES

During FY 2005, two fatality reviews were conducted and three reviews are pending the receipt of all medical information. No recurrent systemic weaknesses were noted in the completed reviews.

# DIVISION OF AGING AND ADULT SERVICES

The Division of Aging and Adult Services reported one fatality during FY 2005. Adult Protective Services conducted an investigation of alleged Emotional Abuse/Harm to a woman with Multiple Sclerosis as reported by the Home Health nurse. The woman denied the allegations but died the day after the APS worker had been in the home. The client's insurance agency questioned the woman's death and wondered if she had committed suicide or if her husband had been involved in her death.

The insurance agency and Home Health Care concerns were reported to law enforcement, but there was not enough information for law enforcement to order an autopsy. The woman's doctor signed her Certificate of Death with the cause of death listed as Debilitation due to Multiple Sclerosis.

The APS investigation appeared to be thorough, the allegations were unsubstantiated based on the conditions that existed at the time of the referral, and there appeared to be no systemic weaknesses related to the services provided.

# DIVISION OF MENTAL HEALTH/DIVISION OF SUBSTANCE ABUSE

## UTAH STATE HOSPITAL

### SYSTEMIC STRENGTHS

Utah State Hospital is to be commended for taking immediate action to improve systemic problems identified in its fatality reviews. Medical staff appear to be knowledgeable about decedents' mental health and medical histories, and they provide informative verbal reports pertaining to treatment histories and to circumstances surrounding patient deaths.

During FY 2005, two fatalities of current or former USH patients were reported, and two fatality reviews were held. Each individual had been released from USH at the time of his/her deaths. A woman diagnosed with a malignant brain tumor had been hospitalized for two months in an attempt to control her behavior so that she could receive additional radiation treatment for the tumor. However, her physical condition continued to decline, and she developed increasing pain. After two months at Utah State Hospital she was discharged to a care center and died there six weeks later.

A twenty-one-year-old man with a diagnosis of paranoid schizophrenia, complicated by depression, alcohol abuse, and poly-substance dependence, was hospitalized for approximately two months. During that time, he completed a substance abuse program, and his mood and thought processes stabilized. The man was discharged to a mental health provider, was active in treatment, was employed, and was making plans to attend college. Much to the shock of his family and mental health staff, the man obtained a gun at his parents' home and took his life with a gunshot wound to the head.

### SYSTEMIC WEAKNESSES

There were no recurring systemic weaknesses identified in the two cases reviewed by Utah State Hospital.

# DIVISION OF JUVENILE JUSTICE SYSTEMS

The Committee reviewed the fatalities of seven Division of Juvenile Justice Services (DJJS) clients. Two of the youth died accidental deaths, one from drowning, the other of injuries sustained in a motor vehicle accident. Two youth committed suicide, both by hanging, and the cause of death for the remaining three youths is undetermined, as each died of mixed drug intoxication. Five of the youth were eighteen years old, one was fifteen, and the other fourteen. Three of the youth were no longer in DJJS custody at the time of death. The other four youth were respectively in Observation and Assessment, a DJJS proctor home, a group home, and an independent living placement.

**SYSTEMIC STRENGTHS**

In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive services that included individual and group therapies, medication management, life skills training, substance abuse treatment programs, educational services, and tracking. Case managers and trackers were diligent in monitoring the well-being and compliance of their clients.

**SYSTEMIC WEAKNESSES**

Due to the small number of cases reviewed for DJJS, the Committee could not generalize concerns to systemic weaknesses. However, the Committee noted one concern that had to do with DJJS' relationship with the juvenile court system. The court gave conflicting orders to DJJS, which were that the decedent was to be placed in a "secure" O & A facility and that there was to be no contact between him and his co-defendant who had already been placed in O & A.

By definition, O & A is a community placement and is not secure. There is only one O & A facility in the state that has locked doors, and the youth's co-defendant had already been placed at that facility. The youth was taken to another O & A facility and ran from it within hours of his arrival. While AWOL, the youth died of mixed drug intoxication.

The Division of Juvenile Justice Services uses a Juvenile Court Sentencing Matrix to determine sentencing options. Under this concept juveniles are addressed earlier in their criminal careers through court intervention, and they receive harsher sentencing if they are repeat offenders. A systemic problem arises when there are youth such as the decedent who are too low on the DJJS matrix to be placed in a DJJS facility, yet they are so reckless or ungovernable that they put themselves and the community at risk. They also do not fit the abuse/neglect criteria of the Division of Child and Family Services. There are no appropriate services for the ungovernable population.

The decedent did not fit the requirements for secure care, and he should have gone to some type of psychiatric in-patient treatment program. However, his parents made a plea in court that their son was a run risk and that he needed a secure placement. The judge ordered Nicholas to a "secure" O & A placement, which does not exist.

# OFFICE OF THE PUBLIC GUARDIAN

During FY 2005, the Office of the Public Guardian reported the deaths of seven clients. The OGP provided the Fatality Review Coordinator with comprehensive summaries of the clients' service histories and with an explanation of the causes of death. It appeared that all decedents received appropriate services and that their deaths were related to age and medical conditions.

# DEPARTMENT OF HUMAN SERVICES
# FATALITY REPORT

## SUMMARY
## FY 2005

| DEPARTMENT/DIVISION | Number of Reported Deaths | Cases Open at Time of Death | Reviews Held | Reviews Waived | Reviews Pending | Male | Female |
|---|---|---|---|---|---|---|---|
| **DEPARTMENT OF HUMAN SERVICES** | **106** | **76** | **103** | **0** | **3** | **52** | **54** |
| **DAAS** ***(Division of Aging and Adult Services)*** | 1 | 1 | 1 | 0 | 0 | 0 | 1 |
| **DCFS** ***(Division of Child and Family Services)*** | 40 | 15 | 40 | 0 | 0 | 24 | 16 |
| **DJJS** ***(Division of Juvenile Justice Services)*** | 7 | 4 | 7 | 0 | 0 | 5 | 2 |
| **DMH** ***(Division of Mental Health)*** **USH** ***(Utah State Hospital)*** | 2 | 1 | 2 | 0 | 0 | 1 | 1 |
| **DSPD** ***(Division of Services for People with Disabilities)*** **COMMUNITY PLACEMENT** | 43 | 43 | 43 | 0 | 0 | 18 | 25 |
| **DSPD** ***(Division of Services for People with Disabilities)*** **USDC** ***(Utah State Developmental Center)*** | 5 | 5 | 2 | 0 | 3 | 3 | 2 |
| **DSPD/DCFS** *(Division of Services for People with Disabilities/Division of Child and Family Services)* | 1 | 1 | 1 | 0 | 0 | 0 | 1 |
| **OPG (*Office of the Public Guardian)*** | 7 | 7 | 7 | 0 | 0 | 1 | 6 |

# CHART I

## SERVICES PROVIDED WITHIN 12 MONTHS OF CLIENT'S DEATH
## FY 2005

**Division of Aging and Adult Services**
Home Health Care - 1

**TOTAL: 1**

**Division of Child and Family Services**
Adoption Subsidy (AAM) - 1
Child Protective Services (CPS) – 26
Voluntary In-home Services (PSC) - 4
Court-ordered In-home Services (PSS/PFP) - 5
Foster Care (SCF) - 4

**TOTAL: 40**

**Division of Juvenile Justice Services**
Group Home – 2
Independent Living – 2
Observation & Assessment – 2
Proctor Home - 1

**TOTAL: 7**

**Division of Mental Health – Utah State Hospital**
Residential - 2

**TOTAL: 2**

**Division of Services for People with Disabilities – Community Placements**
Community Living Support Services - 24*
Day Support Services - 6
Family Support Services (SAM) - 4
Hospice - 3
Personal Assistance Services – 4
Respite - 2
Supported Employment Services - 1

(Most DSPD individuals were open for more than one service. The primary service is listed on this table.)

**TOTAL: 44***

* Total includes services for one DSPD/DCFS client.

**Division of Services for People with Disabilities – Utah State Developmental Center**
Residential - 5

**TOTAL: 5**

**Office of the Public Guardian**
Guardianship Services – 7

**TOTAL: 7**

# CHART II

## FIVE-YEAR COMPARISON

**FY 2001 – FY 2005**

| | FY 2001 | FY 2002 | FY 2003 | FY2004 | FY 2005 |
|---|---|---|---|---|---|
| **DHS Reported Deaths** | **109** | **111** | **106** | **95** | **106** |
| **DAAS** | **2** | **3** | **0** | **1** | **1** |
| **DCFS** | **43** | **36** | **50** | **35** | **40** |
| **DCFS/DMH** | **0** | **1** | **1** | **0** | **0** |
| **DCFS/DSPD** | **1** | **1** | **1** | **2** | **1** |
| **DJJS** | **4** | **2** | **5** | **1** | **7** |
| **DJJS/DCFS** | **0** | **2** | **0** | **0** | **0** |
| **DMH/USH** | **7** | **6** | **7** | **6** | **2** |
| **DSPD** | **42** | **43** | **29** | **39** | **43** |
| **DSPD/USDC** | **8** | **3** | **5** | **8** | **5** |
| **DSPD/DMH** | **2** | **2** | **1** | **0** | **0** |
| **OPG** | **0** | **121** | **7** | **3** | **7** |
| | | | | | |
| **Cases Open at Time of Death** | **86** | **83** | **70** | **66** | **76** |
| **Reviews Held** | **96** | **104** | **96** | **92** | **101** |
| **Abuse & Neglect Deaths** | **10** | **9** | **6** | **9** | **5** |
| **Accidental Deaths** | **16** | **18** | **21** | **10** | **13** |
| **Homicides** | **7** | **7** | **5** | **3** | **4** |
| **Motor Vehicle Related Deaths** | **10** | **7** | **14** | **2** | **8** |
| **Suicides** | **5** | **10** | **11** | **2** | **9** |

1 First reporting year – FY 2002.

# CHART III

## AGE AT TIME OF DEATH

### FY 2005

| AGE IN YEARS | DHS | DAAS | DCFS | DJJS | DMH/ USH | DSPD | DSPD/ usdc | DSPD/ DCFS | OPG |
|---|---|---|---|---|---|---|---|---|---|
| **< 1** | **16** | | 16 | | | | | | |
| **1 – 3** | **5** | | 5 | | | | | | |
| **4- 6** | **4** | | 4 | | | | | | |
| **7- 10** | **2** | | 2 | | | | | | |
| **11 - 14** | **9** | | 4 | 1 | | 4 | | | |
| **15 - 18** | **15** | | 9 | 6 | | | | | |
| **19 - 30** | **6** | | | | 1 | 5 | | | |
| **31 – 50** | **18** | | | | | 13 | 4 | 1 | 1 |
| **51- 65** | **16** | 1 | | | | 13 | 1 | | 1 |
| **66 – 80** | **10** | | | | 1 | 7 | | | 2 |
| **81 - 90** | **5** | 1 | | | | 1 | | | 3 |
| **91 - 100** | **0** | | | | | | | | |
| **TOTALS** | **106** | **1** | **40** | **7** | **2** | **43** | **5** | **1** | **7** |

# CHART IV

## CAUSE OF DEATH

**FY 2005**

| | DHS | DAAS | DCFS | DJJS | DMH/ USH | DSPD | DSPD/ DCFS | DSPD/ USDC | OPG |
|---|---|---|---|---|---|---|---|---|---|
| **Head/Brain Trauma** | **9** | | **5** | **1** | | **3** | | | |
| **Alzheimer's Disease/Dementia** | **1** | | | | | | | | **1** |
| **Asphyxia** | **10** | | **7** | **3** | | | | | |
| **Bacterial Infection/Sepsis** | **7** | | **3** | | | **3** | | | **1** |
| **Blunt Force Injuries** | **4** | | **3** | | | **1** | | | |
| **Cancer** | **1** | | | | **1** | | | | |
| **Drug Intoxication** | **5** | | **2** | **3** | | | | | |
| **Gunshot Wound** | **4** | | **3** | | **1** | | | | |
| **Heart-related Problems** | **21** | | **1** | | | **16** | **1** | | **3** |
| **Multiple Sclerosis** | **2** | **1** | | | | **1** | | | |
| **Organ Failure** | **4** | | | | | **3** | | | **1** |
| **Other** | **2** | | **1** | | | **1** | | | |
| **Pneumonia** | **10** | | **1** | | | **7** | | **2** | |
| **Premature Birth** | **8** | | **8** | | | | | | |
| **Respiratory/Pulmonary** | **8** | | **2** | | | **5** | | **1** | |
| **Seizure Disorder** | **1** | | | | | | | **1** | |
| **SIDS** | **2** | | **2** | | | | | | |
| **SIDS vs. Positional Asphyxia** | **2** | | **2** | | | | | | |
| **Undetermined/Pending** | **5** | | | | | **3** | | **1** | **1** |
| **TOTALS** | **106** | **1** | **40** | **7** | **2** | **43** | **1** | **5** | **7** |

# CHART V
## SUICIDE DEATHS
### FY2005

| MANNER OF SUICIDE | GENDER | AGE | DCFS | DJJS | USH |
|---|---|---|---|---|---|
| Gunshot Wound | MALE<br>FEMALE | 13, 15, 21 | 2<br>0 | | 1<br>0 |
| Hanging | MALE<br>FEMALE | 10, 17, 18, 18<br>11, 17 | 2<br>2 | 2<br>0 | |
| TOTALS | MALE – 7<br>FEMALE- 2 | | 6 | 2 | 1 |

# CHART VI
## HOMICIDE DEATHS
### FY2005

| MANNER OF HOMICIDE | GENDER | AGE | DCFS |
|---|---|---|---|
| Asphyxiation | MALE | 17 months | 1 |
| Gunshot Wound | MALE | 16 years | 1 |
| Inflicted Head Injury | MALE<br>FEMALE | 4 years<br>17 months | 1<br>1 |
| TOTALS | MALE – 3<br>FEMALE - 1 | | 4 |

# CHART VII
## ACCIDENTAL DEATHS
### FY2005

| CAUSE OF DEATH | GENDER | AGE | DCFS | DJJS | DSPD |
|---|---|---|---|---|---|
| Asphyxia – Mudslide | MALE | 9 | 1 | | |
| Auto/Pedestrian Accident | MALE<br>FEMALE | 2, 4, 52<br>81 | 2<br>0 | | 1<br>1 |
| Drowning | MALE<br>MALE | 11<br>15 | 1 | <br>1 | |
| Fall | MALE | 66 | | | 1 |
| Motor Vehicle Accident | MALE<br>FEMALE | 18<br>15, 16, 16, 17 | 0<br>4 | 1<br>0 | |
| TOTALS | MALE - 8<br>FEMALE - 5 | | 8 | 2 | 3 |

# CHART VIII
## ABUSE/NEGLECT DEATHS
### FY 2005

| CAUSE OF DEATH | DHS | DCFS | DSPD |
|---|---|---|---|
| Asphyxiation | 1 | 1 | |
| Blunt/Inflicted Head Trauma | 2 | 2 | |
| Respiratory Failure | 1 | | 1 |
| Sepsis | 1 | | 1 |
| TOTALS | 5 | 3 | 2 |

# CHART IX
## MEDICAL EXAMINER'S DETERMINATION
## MANNER OF DEATH
### FY 2005

| MANNER OF DEATH | DHS | DAAS | DCFS | DJJS | DMH/ USH | DSPD | DSPD/ DCFS | DSPD/ USDC | OPG |
|---|---|---|---|---|---|---|---|---|---|
| Accident | 13 | | 8 | 2 | | 3 | | | |
| Homicide | 4 | | 4 | | | | | | |
| Natural Causes | 72 | 1 | 18 | | 1 | 40 | 1 | 4 | 7 |
| Pending | 1 | | | | | | | 1 | |
| Suicide | 9 | | 6 | 2 | 1 | | | | |
| Undetermined | 7 | | 4 | 3 | | | | | |
| TOTALS | 106 | 1 | 40 | 7 | 2 | 43 | 1 | 5 | 7 |